NEW PATIENT PAPERWORK

GENERAL INFORMATION

NAME: _____ AGE: _____ SEX: Male / Female
ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
CELL PHONE: _____ BIRTHDATE: _____
EMAIL ADDRESS: _____
REFERRED BY: _____ PREFERRED NAME: _____

Please Select Payment Option: ○ Keep Card on File ○ At Time of Service

INSURANCE

I clearly understand that all insurance coverage, whether accident, work related, or general coverage is an arrangement between my insurance carrier and myself. This office will provide any necessary reports or required information to aid in insurance reimbursement of services, but I understand that insurance carriers may deny my claims and I am ultimately responsible for any unpaid balances.

Patient Signature: _____ Date: _____
Insurance Company: _____ Phone: _____
ID/Subscriber #: _____ Group #: _____

CONSENT FOR CARE

I give the doctors, therapists and staff permission and authority to care for me in accordance with testing, diagnosis, analysis and treatment. I am responsible to inform you of any symptoms, conditions, or issues which would otherwise not come to their attention.

Patient Signature: _____ Date: _____
Parent/Guardian Signature: _____ Date: _____

HIPPA NOTICE

I acknowledge the following:

1. The privacy notice is available to me now and at any time in the future.
2. Appointment reminders may be used by the practice via email, phone or postcards.
3. I understand that if I revoke this consent at any time, the practice has the right to refuse treatment.
4. I authorize the release of my medical information to the following person(s): _____

Patient Signature: _____ Date: _____

Woodhaven Health PC
600 Blair Park Rd. Ste 200
Williston, VT 05495
Phone: (802) 857-5099
Fax: (802) 857-5179
contact@woodhavenhealth.com

WHAT BRINGS YOU IN TODAY?

Location of pain/symptoms: _____
What would you rate your pain at it's worst (1-10, ten being the worse pain possible): _____
Please describe the pain: _____
Any numbness or tingling: Yes / No Where: _____
Any radiating or shooting pain/symptoms: Yes / No Where: _____
When did this begin: _____
How did this happen: _____
Is this related to auto accident or work injury: Yes / No Which one: Auto / Work
What makes your pain/symptoms worse: _____
What help or relieves you pain/symptoms: _____
Is there a time of the day that your pain/symptoms are better or worse: _____
Have you experienced these pain/symptoms before: Yes / No When: _____
Who have you seen for this: _____
What did they do: _____
How did you respond: _____

LIFESTYLE

Do you exercise? Yes / No How often and what activities: _____
Do you smoke? Yes / No How much per day: _____
Do you drink alcohol? Yes / No How much per week: _____
Do you drink caffeine? Yes / No How much per day: _____
How many cups of water do you drink per day: _____
List any vitamins and supplements: _____
List any medications: _____

HEALTH CONDITIONS

Cervical (Neck) Region:

- Neck Pain
- Headaches/Migraines
- Seizures/Epilepsy
- Pain in shoulders/arms/hands
- Dizziness
- TMJ pain/clicking
- Weakness in grip
- Numb/tingling in arms/hands

Thoracic (upper and middle back) Region:

- Upper back pain
- Middle back pain
- Pain in ribs/chest
- Pain on deep breathing

Lumbar (low back) or Pelvis (hips) Region:

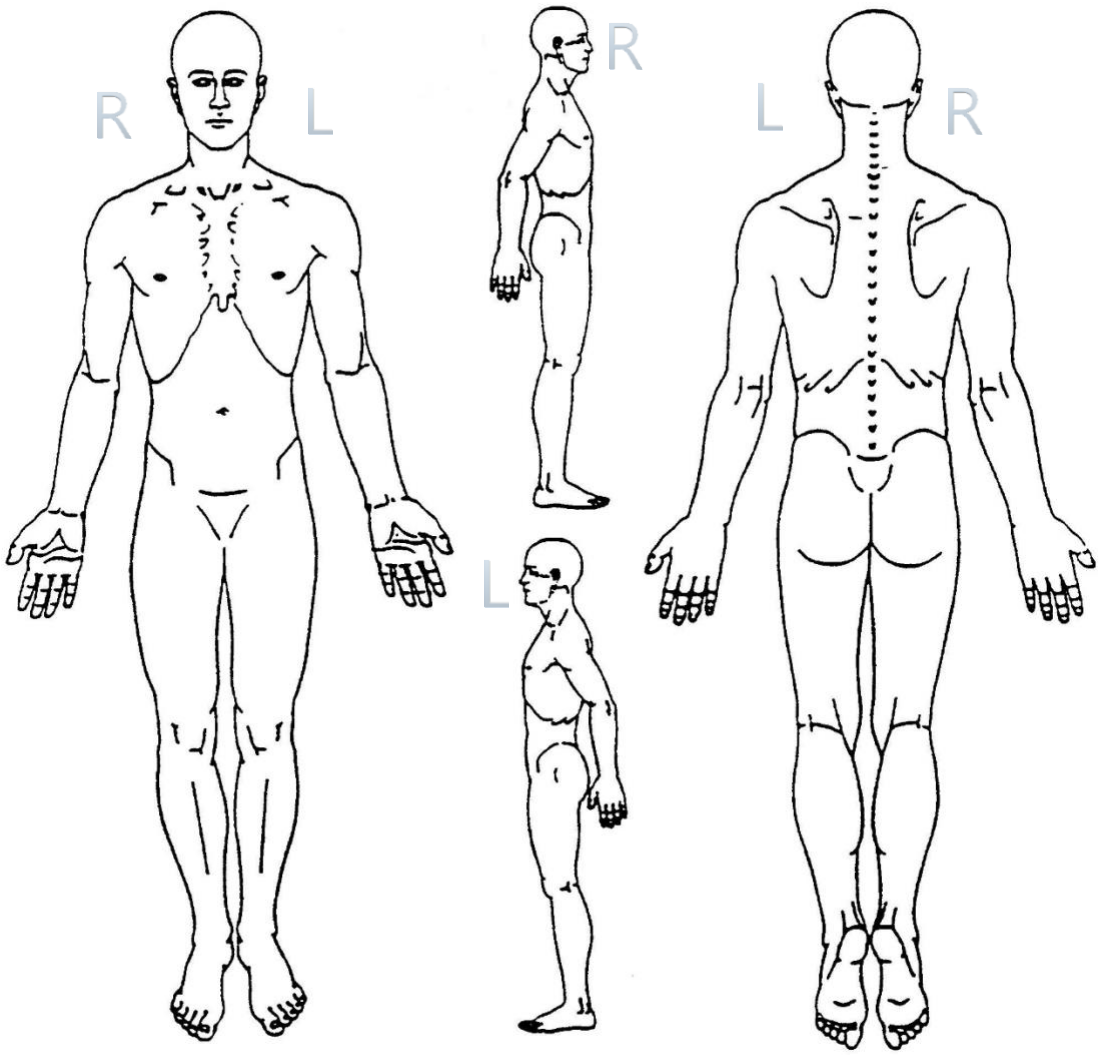
- Low back pain
- Pain in hips/legs/feet
- Weak in legs/feet
- Numb/tingling in legs/feet

List any allergies: _____
_____
List all surgeries with date: _____
_____
List any other health condition not mentioned: _____
_____

PAIN DIAGRAM

Use the symbols below to show the area, upon the body outline, in which you are experiencing pain.

Ache – A Burn – B Numbness – N Pins & Needles – P Stabbing – S Other – O



The line below represents the intensity of the pain you are experiencing. Please make an "X" at the position on the scale the indicates how much pain you are experiencing ***at this time.***

No Pain 0 ——————————————————————————— **10 Worst Pain**

Neck Disability Index

This questionnaire has been designed to give us information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and **mark in each section only the one box that applies to you**. We realise you may consider that two or more statements in any one section relate to you, but please just mark the box that most closely describes your problem**.**

Office Use Only

Name _____

Date _____

Section 1: Pain Intensity

☐ I have no pain at the moment
☐ The pain is very mild at the moment
☐ The pain is moderate at the moment
☐ The pain is fairly severe at the moment
☐ The pain is very severe at the moment
☐ The pain is the worst imaginable at the moment

Section 2: Personal Care (Washing, Dressing, etc.)

☐ I can look after myself normally without causing extra pain
☐ I can look after myself normally but it causes extra pain
☐ It is painful to look after myself and I am slow and careful
☐ I need some help but can manage most of my personal care
☐ I need help every day in most aspects of self care
☐ I do not get dressed, I wash with difficulty and stay in bed

Section 3: Lifting

☐ I can lift heavy weights without extra pain
☐ I can lift heavy weights but it gives extra pain
☐ Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently placed, for example on a table
☐ Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
☐ I can only lift very light weights
☐ I cannot lift or carry anything

Section 4: Reading

☐ I can read as much as I want to with no pain in my neck
☐ I can read as much as I want to with slight pain in my neck
☐ I can read as much as I want with moderate pain in my neck
☐ I can't read as much as I want because of moderate pain in my neck
☐ I can hardly read at all because of severe pain in my neck
☐ I cannot read at all

Section 5: Headaches

☐ I have no headaches at all
☐ I have slight headaches, which come infrequently
☐ I have moderate headaches, which come infrequently
☐ I have moderate headaches, which come frequently
☐ I have severe headaches, which come frequently
☐ I have headaches almost all the time

Section 6: Concentration

☐ I can concentrate fully when I want to with no difficulty
☐ I can concentrate fully when I want to with slight difficulty
☐ I have a fair degree of difficulty in concentrating when I want to
☐ I have a lot of difficulty in concentrating when I want to
☐ I have a great deal of difficulty in concentrating when I want to
☐ I cannot concentrate at all

Section 7: Work

☐ I can do as much work as I want to
☐ I can only do my usual work, but no more
☐ I can do most of my usual work, but no more
☐ I cannot do my usual work
☐ I can hardly do any work at all
☐ I can't do any work at all

Section 8: Driving

☐ I can drive my car without any neck pain
☐ I can drive my car as long as I want with slight pain in my neck
☐ I can drive my car as long as I want with moderate pain in my neck
☐ I can't drive my car as long as I want because of moderate pain in my neck
☐ I can hardly drive at all because of severe pain in my neck
☐ I can't drive my car at all

Section 9: Sleeping

☐ I have no trouble sleeping
☐ My sleep is slightly disturbed (less than 1 hr sleepless)
☐ My sleep is mildly disturbed (1-2 hrs sleepless)
☐ My sleep is moderately disturbed (2-3 hrs sleepless)
☐ My sleep is greatly disturbed (3-5 hrs sleepless)
☐ My sleep is completely disturbed (5-7 hrs sleepless)

Section 10: Recreation

☐ I am able to engage in all my recreation activities with no neck pain at all
☐ I am able to engage in all my recreation activities, with some pain in my neck
☐ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck
☐ I am able to engage in a few of my usual recreation activities because of pain in my neck
☐ I can hardly do any recreation activities because of pain in my neck
☐ I can't do any recreation activities at all

Score: ___/50 Transform to percentage score x 100 = %points

REVISED OSWESTRY LOW BACK PAIN DISABILITY QUESTIONNAIRE

PLEASE READ: This questionnaire is designed to enable us to understand how much your low back pain has affected your ability to manage your everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may relate to you, but **PLEASE JUST CIRCLE ONE CHOICE WHICH MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.**

SECTION 1 – Pain Intensity
A. The pain comes and goes and is very mild.
B. The pain is mild and does not vary much.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain comes and goes and is severe.
F. The pain is severe and does not vary much.

SECTION 2 – Personal Care
A. I would not have to change my way of washing or dressing in order to avoid pain.
B. I do not normally change my way of washing or dressing even though it causes some pain.
C. Washing and dressing increases the pain, but I manage not to change my way of doing it.
D. Washing and dressing increases the pain and I find it necessary to change my way of doing it.
E. Because of the pain, I am unable to do some washing and dressing without help.
F. Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 – Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weight off the floor.
D. Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, eg. on a table.
E. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
F. I can only lift very light weights, at the most.

SECTION 4 – Walking
A. Pain does not prevent me from walking any distance.
B. Pain prevents me from walking more than one mile.
C. Pain prevents me from walking more than ½ mile.
D. Pain prevents me from walking more than ¼ mile.
E. I can only walk while using a cane or on crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 – Sitting
A. I can sit in any chair as long as I like without pain.
B. I can only sit in my favorite chair as long as I like.
C. Pain prevents me from sitting more than one hour.
D. Pain prevents me from sitting more than ½ hour.
E. Pain prevents me from sitting more than ten minutes.
F. Pain prevents me from sitting at all.

SECTION 6 – Standing
A. I can stand as long as I want without pain.
B. I have some pain while standing, but it does not increase with time.
C. I cannot stand for longer than one hour without increasing pain.
D. I cannot stand for longer than ½ hour without increasing pain.
E. I cannot stand for longer than ten minute without increasing pain.
F. I avoid standing, because it increases the pain straight away.

SECTION 7 – Sleeping
A. I get no pain in bed.
B. I get pain in bed, but it does not prevent me from sleeping well.
C. Because of pain, my normal night's sleep is reduced by less than one quarter.
D. Because of pain, my normal night's sleep is reduced by less than one-half.
E. Because of pain, my normal night's sleep is reduced by less than three-quarters.
F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life
A. My social life is normal and give me no pain.
B. My social life is normal, but increases the degree of my pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, My dancing, etc.
D. Pain has restricted my social life and I do not go out very often.
E. Pain has restricted my social life to my home.
F. I have hardly any social life because of the pain.

SECTION 9 – Traveling
A. I get no pain while traveling.
B. I get some pain while traveling, but none of my usual forms of travel make it any worse.
C. I get extra pain while traveling, but it does not compel me to seek alternative forms of travel.
D. I get extra pain while traveling which compels me to seek alternative forms of travel.
E. Pain restricts all forms of travel.
F. Pain prevents all forms of travel except that done lying down.

SECTION 10 – Changing Degree of Pain
A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

COMMENTS: _____

_____

_____

_____

_____

_____

PATIENT NAME: _____ **DATE:** _____ **SCORE:** _____

WOODHAVEN
HEALTH

CREDIT/DEBIT CARD PAYMENT AUTHORIZATION FORM

B. PATIENT INFORMATION

Last Name _____ First Name _____

A. CARD INFORMATION

Name as it appears on Credit/Debit Card _____

Mailing Address _____

City _____ State _____ Zip _____

CARD NUMBER _____ - _____ - _____ - _____

_____ / _____ _____

Expiration Date CVV Code

C. CREDIT/DEBIT CARD AUTHORIZATION

I authorize Woodhaven Health or its authorized credit/debt card transaction agent(s) to bill my credit/debt card account indicated above for payment of each single visit charged for services & treatment that is received.

Signature: _____ Date:_____

Please note: Your card billing date may not occur on your treatment date due to insurance processing times. Your charge may be up to 30 days delayed. Please contact us for further details.

D. RECEIPT

Please Select One: ○ No receipt needed
○ Yes, please email me a receipt at _____